



**Department
of Health**

An Introduction to the NYS Early Intervention Program

November 16, 2016

Agenda

- A Brief History of the Early Intervention Program (EIP)
- Guiding Principles
- Structure and Services
- Steps of the EI Process

What is the EIP?

The NYS Early Intervention Program (EIP) is part of the national Early Intervention Program for infants and toddlers with disabilities and their families.

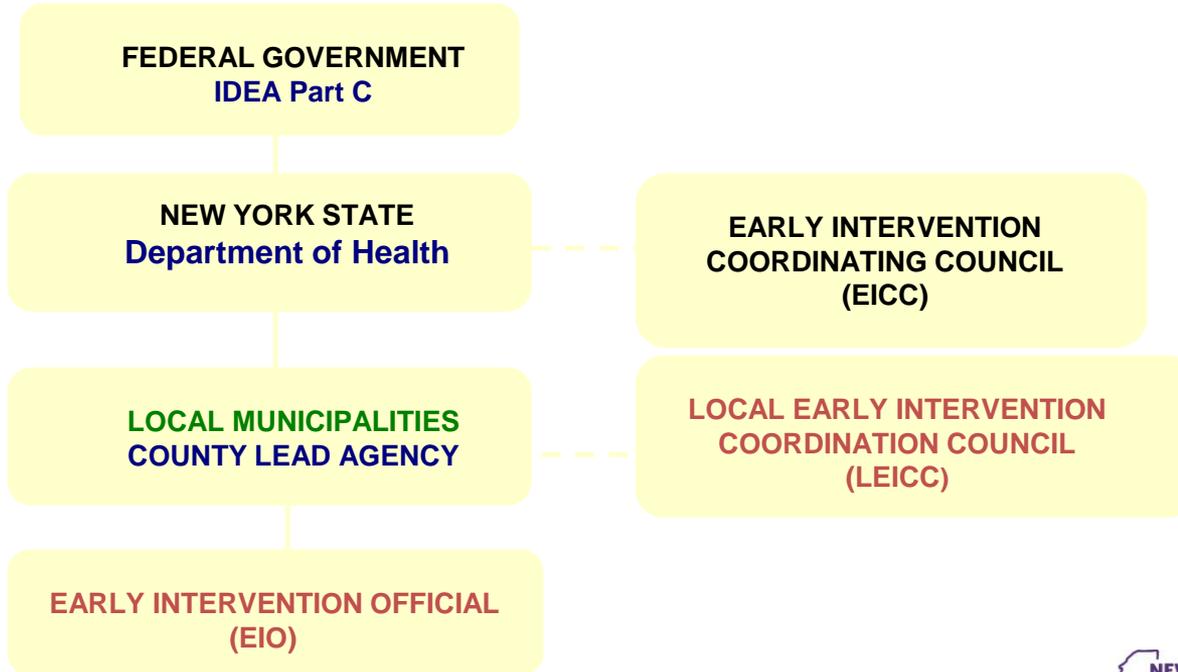
First created by Congress in 1986 under the Individuals with Disabilities Education Act (IDEA), the EIP is administered by the New York State Department of Health through the local county Health Departments or other designated county offices. In New York State, the Early Intervention Program is established in Article 25 of the Public Health Law and has been in effect since July 1, 1993.

To be eligible for services, children must be under 3 years of age and have a confirmed disability or established developmental delay, as defined by the State, in one or more areas of development.

Guiding Principles of EIP

Family Centered
Natural Environments & Activities
Coordinated Services
Evidence-Based Practice
Available and Accessible for All Families

EIP Structure



Early Intervention Steps

FAMILY CONCERN



REFERRAL

1. Referral

(unless parent objects)

- Referral source or parent suspects child of having developmental delay or disability
- Family informed of benefits of Early Intervention Program
- Child referred to EIO within 2 days of identification
 - Early Intervention Official assigns Initial Service Coordinator



COORDINATOR

2. Initial Service Coordinator

- Provide information about EIP
- Inform family of rights
- Review list of evaluators
- Obtain insurance/Medicaid information
- Obtain other relevant information

3. Evaluation*

(with parents' consent)

- Determine eligibility
- Family assessment, optional
- Gather information for IFSP
 - Summary and report submitted prior to IFSP



EVALUATION



THE IFSP MEETING

4. The IFSP Meeting*

(if child is eligible)

- Family identifies desired outcomes
- Early Intervention services specified
- Develop written plan
- Family and EIO agree to IFSP
- Identify Ongoing Service Coordinator

Early Intervention Services*

- assistive technology devices and services
- audiology
- family training, counseling, home visits and parent support groups
- medical services only for diagnostic or evaluation purposes
- nursing services
- nutrition services
- occupational therapy
- physical therapy
- psychological services
- service coordination
- social work services
- special instruction
- speech-language pathology
- vision services
- health services
- transportation and related costs

Areas of Development

- cognitive
- physical (including vision and hearing)
- communication
- social/emotional
- adaptive development

* May access due process procedures

5. Review Six Months/Evaluate Annually

- Decision is made to continue, add, modify or delete outcomes, strategies, and/or services
- If parent requests, may review sooner



REVIEW AHEAD

6. Transition

- Plan for transition included in IFSP
- Transition to:
 - services under Section 4410 of Education Law (3-5 system)
 - OR
 - other early childhood services



TRANSITION

EIP- Referral Process

- A primary referral **source or parent/guardian** refers a child to the EIP when the child has a diagnosed condition or it is suspected the child has a **developmental delay or disability** in one or more of the 5 general developmental domains
- The parent is informed of benefits of the EIP
- A child is referred to the **Early Intervention Official (EIO)** in the child's county of residence (**45 day timeline begins**)
- EIO assigns **Initial Service Coordinator (ISC)** for the child/family.

Parental Rights in the EIP

Parent/Guardian has the right to:

- Take part in all decisions
- Meet at times and locations that are best for their schedules
- Give their permission at every step of the process (informed consent)
- Confidentiality
- Access to Records

Due Process:

- Mediation
- Systems Complaints
- Impartial Hearing

Initial Service Coordinator

- Meets with the family to provide information about the EIP and the process that will need to take place for establishing EI eligibility to receive services.
- Explains to family that participation in the EIP is voluntary.
- If the family wants to participate in the EIP, the ISC:
 - informs family of their rights related to the EIP program
 - Informs the family of the evaluation process to establish eligibility
 - Reviews a list of approved evaluators for the family to choose
 - Obtains third party insurance and/ or Medicaid information from the family so that appropriate billing for EI services can occur
 - Obtains other relevant information that may be needed to assist the family (e.g. public health programs, Medicaid assistance programs)

Multidisciplinary Evaluation (MDE)

- Parent/guardian chooses evaluator from EIP approved provider list they were given by their ISC
- ISC assists in the arrangement of the MDE
- With parent consent, gives information specific to the child and family to the evaluators so they can prepare for the evaluation
- ISC may attend the evaluation if requested by the parent

Multidisciplinary Evaluation (MDE)

Children with certain diagnosed conditions are automatically eligible for the EIP.

For these children, the purpose of the MDE is to assess the child's strengths, needs, and current level of functioning in all areas of development.

For children who do not have diagnosed conditions or have diagnosed conditions that are not automatically eligible for the EIP, the purpose of the MDE is to assess the child's strengths, extent of their needs, and current level of functioning in all areas of development to establish eligibility for the EIP.

Who performs the MDE?

“Multidisciplinary” means that a team of qualified professionals from different disciplines or professions will take part in the evaluation.

In the EIP, the MDE team is comprised of two or more qualified personnel from different discipline with at least one of the members being a specialist in the area of the child’s suspected delay or disability.

(Example: Parent/guardian is concerned about their 18 month old child’s ability to communicate her wants and needs to others. The 2 evaluation team members sent to do the MDE are a Speech Language Pathologist and a Special Educator with Certification Birth to Grade 2)

Developmental Assessment Screening and Testing

- MDE team members complete an assessment of the child's skills across the 5 developmental domains
- DOH approved formalized testing tools are utilized
- Includes informal observations of the child in their natural environment (if possible) and use of professional judgement
- Includes information from interviewing the parent/guardian
- Includes review of information that the parent has consented to share from other sources such as childcare providers or other evaluations previously completed
- MDE team members determine the child's current level of functioning in each developmental domain
- Parents/guardians help the evaluation team elicit optimal responses from the child, provide explanations of child behavior during the evaluation and provide feedback about their child's performance during the evaluation.

Five Developmental Domains

1. **Cognitive** – includes the child’s awareness and attention, thinking and problem-solving as well as the ability to formulate concepts.
2. **Communication** – includes pre-linguistic behavior such as babbling, imitating sounds, and pointing; the use and understanding of language and the development of sounds and speech, including articulation and fluency.
3. **Adaptive** – includes daily living skills and coping ability.
4. **Social-Emotional** – includes self-awareness, self-regulation, and interaction with people and the environment.
5. **Physical Development** – includes fine motor, gross motor, vision, hearing and sensory development.

Family Assessment (optional to family)

- Family directed and used to help a family determine the resources, priorities, and concerns they have related to caring for and enhancing their child's development
- Helps the family to think about what they need most from EI services and from other community services or supports which may be available to them.
- Summarizes the family's current resources including transportation needs and if they have a child safety seat for when they do travel
- The family decides what information from the voluntary family assessment should/can be included in the evaluation report, and what can be discussed later at a team meeting.

Eligibility Criteria

Five Developmental Domains

Cognition Communication Adaptive
Social-Emotional Physical

It is the responsibility of the
Multidisciplinary Evaluation Team to
determine eligibility

Delay in a Single Domain
33% OR
12 Month OR
2 Standard Deviations

Delay in Two or More Domains
25% each OR
1.5 Standard Deviations Each

Diagnosed Condition
Having a high probability of resulting
in developmental delay

Communication Domain Delay Only
2 Standard Deviations below the
mean



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MDE Summary and Report

At the conclusion of the MDE, evaluation team members provide a **verbal and written summary** of their findings to the family and to the Initial Service Coordinator

This includes discussion of whether or not the child's diagnosis or evaluation findings establish the child's eligibility for the EIP (based on the information gathered during the MDE process)

Evaluators prepare a comprehensive, formal evaluation report. The report includes an account of the MDE proceedings, assessment findings and any parent/guardian concerns and family needs they have provided consent for the team to report. The MDE is shared with the parent, EIO, ISC and, with parent consent, the Primary Care Provider. If a child is in foster care, the LDSS Commissioner or designee is also sent a copy.

If EIP eligibility is established and parent/guardian wants to proceed, the ISC schedules an Initial IFSP meeting date, time and location convenient for the family.

The MDE report must be submitted to the ISC and received by the parent/guardian prior to convening an Initial Individualized Family Service Plan (IFSP) Meeting.

The Initial IFSP meeting must take place before the end of the 45 day timeline which began at referral

The Individualized Family Service Plan (IFSP)

- **Individualized** – the plan is designed for a particular child and family
- **Family** – the plan is about the family and the outcomes they hope to reach for their child
- **Service** – the plan includes details about the when, who, how, and where of services
- **Plan** – the plan is written to be referred back to, with modifications as needed

The Initial IFSP Meeting

If the child is eligible for the EIP and the parent/guardian consents to proceed in the program, a meeting is held to discuss and develop the **Individualized Family Service Plan (IFSP)**

Who attends:

- Parent/guardian and anyone they invite to attend (grandparent, child care provider, friend, advocate)
- The ISC and the Early Intervention Official/Designee
- Member(s) of the MDE team

The IFSP meeting must include:

Review of the Evaluation

Meeting participants review and discuss all of the information collected about the child's development during the evaluation process

Identification of desired outcomes

Identify the family's resources, priorities and concerns related to their child's development

Determine what outcomes (improvements) the family would like to see for their child and how the EIP will help the child/family

Early Intervention services specified

Discussion/determination of what specific services are included in the IFSP to meet the child and family outcomes and needs, including Ongoing Service Coordination (OSC)

Early Intervention Services

EIP Services meet a wide range of needs

Educational (e.g. Special Instruction, Family Training and Support)

Medical (e.g. nursing services, vision services, audiology services)

Therapeutic (e.g. occupational, physical, speech, social work)

Assistive Technology Devices/Services (e.g. hearing aids, specialized adaptive equipment, communication devices)

Other Related Needs (e.g. Transportation to/from services, any special/related costs, respite care)

The IFSP

- Identifies EI services, and at what frequency and duration will be appropriate for the child/family
- Identifies location- in the child's natural environment-where the services will take place (e.g. home and community locations, facility, parent-child groups, developmental group intervention at a provider's site or community setting with other young children)
- Includes parent consent to accept and initiate the IFSP as written
- Identifies the Ongoing Service Coordinator (OSC) chosen by the parent
- Includes a plan for the child's transition out of the Early Intervention Program to programs under Education Law, Section 4410, and/or to other early childhood services
- Is reviewed at 6 months and annual meetings attended by IFSP team are held to review progress, discuss and revise outcomes as needed, make changes in services as agreed to by the team
- Can be reviewed more frequently, if needed, to discuss changes

Ongoing Service Coordinator (OSC) Responsibilities

- Responsible for implementing the IFSP and ensures that agreed upon services are delivered according to required timelines – within 30 days of the IFSP meeting
- Assist the family with securing services, service providers and any ongoing and changing needs of the child/family
- Maintains ongoing contact with providers and parents to periodically review progress or changes in the needs of the child and family
- Coordinates EI services with other services the family may be receiving
- Addresses problems or issues with services to the EIO, as needed
- Ensures all IFSP meetings are completed within required timelines
- Updates family insurance information as needed
- Completes transition activities and adheres to timelines for Federal and State requirements

Transition out of the Early Intervention Program

A transition plan shall be established in the IFSP to ensure a smooth transition for every child exiting the Early Intervention Program.

Transition plan established in the IFSP must be developed with the child's family and discussed at each IFSP review and meeting.

A transition plan includes:

- The child's current progress, strengths and needs
- A review of program and service options for the child from the child's third birthday through the remainder of the program year
- Steps for the child and his/her family to exit from the EIP
- Determination if services from other state and local agencies is needed
- Transition services that the IFSP team determine are needed by the child and family to support the transition of the child
- Community resources available to assist the child and family
- Steps and services to help the child and family adjust to a new service setting
- Appropriateness/need for notification of the child's potential eligibility to the Committee on Preschool Special Education (CPSE)
- The nature of child's disability/developmental delay, progress made in EI, abilities and needs, evaluation/assessment results, family's needs/input and input from current service providers

Transitioning from the Early Intervention Program

The EIP serves eligible children and their families from **Birth to age 3**.

Children transition from the EIP:

- When they have progressed to the point where they no longer qualify for, or need services
- The day before their third birthday if they have not been found eligible for preschool special education services (CPSE services under Section 4410 of the Education Law)
- When they begin preschool special education services through the New York State Education Department Program serving children 3-5 years of age (CPSE services under Section 4410 of Education Law) through their home school district.

Ongoing Service Coordinator (OSC) Responsibilities related to Transition

- Required specific time lines must be met for transition activities in order to meet federal and State requirements and to ensure that services continue for the child with minimal interruption
- Ensure that a transition conference occurs, unless the parent declines
- The OSC must provide the parent/guardian with detailed transition information and review options for the Notification to CPSE services, if the child is found eligible, or to other community programs
- Ensure consents are obtained to provide copies of EI evaluations and other documents to the CPSE
- Assist parent to refer their child to the CPSE, if the parent requests
- Attend CPSE meeting with the parent, if the parent requests

Notification to CPSE of Child Transition

For children thought to be eligible for services under Section 4410 of the Education Law, not fewer than 90-days prior to the child's potential eligibility for services under Section 4410 of the Education Law, the OSC shall provide written notification to the Committee on Preschool Special Education (CPSE) of the local school district in which an eligible child resides of the potential transition of the child.

- The parent is afforded at least 30 calendar days from the date the parent is informed that they may object, either orally or in writing, to the written notification to the CPSE of the child's potential transition.
- The OSC must document that the parent/guardian has "opted out" of notification to CPSE.
- The OSC should inform the parent/guardian that they can refer their child to the CPSE in the future.
- If the parent/guardian does not opt out within 30 days, it is the OSCs responsibility to send written notification to the CPSC.
- The OSC must confirm the transmission of the notification to the CPSE.

Transition Conference

The purpose of the transition conference is to provide the parent/guardian with an opportunity to meet with the OSC and the CPSE chair, to help inform the parent's decision about referring their child to the CPSE

- The transition conference is required and must be offered to the parent/guardian, however, the parent may decline a transition conference.
- If the parent declines a transition conference, the parent must be informed that the child's eligibility for services under Section 4410 of the Education Law must be determined by the child's 3rd birthday to continue to receive EI services after the child's 3rd birthday. If a determination of eligibility for preschool services has not been made by the CPSE prior to the child's 3rd birthday, eligibility for EI services will end on the day before the child's 3rd birthday.
- With parent consent, the OSC must convene a transition conference with the parent, service coordinator and the chairperson of the CPSE or designee, at least 90 days prior to the child's eligibility for services under Education Law, Section 4410, or no fewer than 90 days before the child's third birthday, which ever is first, provided, however, that the conference cannot be held more than 9 months prior to the child's third birthday, to review program options and establish a transition plan
- The OSC is required to attend and invite parent/guardian, EIO or Designee, and CPSE Chair or designee. The LDSS Commissioner may participate for children in foster care.
- If the CPSE Chair or designee does not attend, the transition conference should still occur unless the parent/guardian declines and documentation of the invitation must be maintained.
- If the CPSE Chair or designee does not attend, the OSC is responsible to provide information to the parent/guardian about CPSE services.

Referral to CPSE

If a child is potentially eligible for CPSE services, under Section 4410 of the Education Law, the parent can refer their child, or provide consent for the OSC to refer the child to the CPSE of the local district in which the child resides if a transition conference has occurred or has been declined by the parent.

The OSC shall provide the parent with information on how the parent may make the referral or can provide assistance to refer the child to the CPSE, including sending parent referral information, as long as parent consents.

The timeline of 90 days prior to the child's third birthday is recommended as the last day that referral should occur.

The OSC must transmit EI evaluations, assessments, IFSPs and other pertinent EI records to the CPSE with parent consent

Eligibility for EIP Services

EIP services must end on the day before a child's 3rd birthday if a referral to CPSE has not been made and/or there has been no determination of eligibility for CPSE.

Therefore, it is important for the OSC to ensure that all transition activities are completed within required time frames and that a transition plan was developed for each child in the EIP which included transition to CPSE or to other appropriate early childhood community supportive services and programs.

The OSC is responsible to assist the parent in identifying, locating and accessing these services.

Early Intervention Resources

Visit the BEI Web page for

- EI Program regulations
- Memoranda and guidance documents
- EI Publications
- Provider Directory
- How to make a referral
- Obtain municipal contacts
- Sign up for BEI's electronic mailing list
- And other helpful information

www.nyhealth.gov/community/infants_children/early_intervention/



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Health Homes Serving Children Integration with Early Intervention

Stakeholder Engagement Session

How do we integrate EI/HH services?

- Is there any alignment among Early Intervention service coordination roles, responsibilities and goals with that of the Health Home Care Management Agency?



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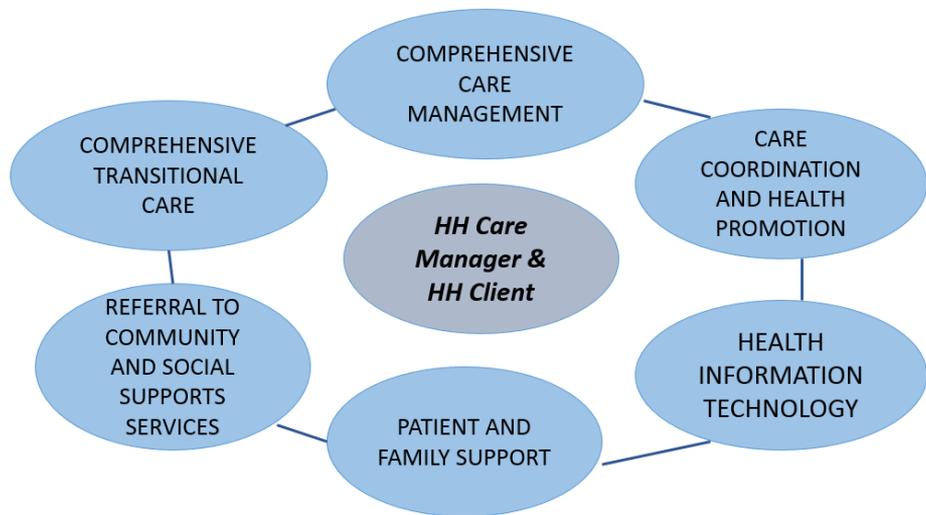
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Health Homes Serving Children Standards

Six Core Services

Health Homes Provide Six Core Care Management Functions



Health Home care management is “whole-person” and “person-centered” and integrates a care philosophy that includes both physical/behavioral health care with family and social supports

Detailed description of activities that comprise the six core services available in Standards Document and Examples are Provided in Appendix of this Webinar

Early Intervention Service Coordination

- Coordinate Early Intervention services
- Development and monitoring of the Individualize Family Service Plan (IFSP)
- Participate in IFSP meetings to develop the child's and family's service needs
- Arrange for EI service providers
- Maintain documentation of all service coordination activities in the child's record, including circumstances that impact timeliness
- Coordinate, facilitate, and monitor the delivery of services to ensure they are being delivered in a timely manner in accordance with the IFSP
- Develop the transition plan to preschool or other appropriate supports and services and complete the required transition steps and services



Alignment in Core Services

- Is there any alignment among Early Intervention roles, responsibilities and service coordination goals with that of the Health Home Care Manager?
 - The following parallels exist between EI and HH
 - ✓ **Coordinate and arrange provision of integrated services**
 - ✓ **Develop and implement a care plan/IFSP**
 - ✓ **Support adherence to treatment recommendations**
 - ✓ **Monitor and evaluate clinical and functional outcomes**
 - ✓ **Identify and facilitate use of community resources**
 - ✓ **Develop a comprehensive transition plan**



Various *DRAFT* Options for Providers

- ✓ Early Intervention Providers who provide Service Coordination (Initial and or Ongoing) can also become Health Home Care Management Agency
 - Service Coordination providers would need to meet HH Care Management Agency (CMA) standards and requirements
 - Service Coordination who become HH CMAs need to affiliate with a lead Health Home and be in their network
- ✓ Health Home Care Management agency can also become an Early Intervention service coordination provider
 - HH CMA would need to be approved by DOH as a Early Intervention provider for service coordination and meet all EI standards and requirements
- ✓ Early Intervention service coordination provider could contract with a Health Home or HH Care Management Agency
 - Would need to establish clear roles, responsibilities and integration of service delivery to limit confusion to the family
 - Would need to establish a payment arrangement, as both entities can not bill for service coordination (Medicaid Target Case Management)



Direct Communication between Health Homes and Early Intervention

- ✓ Health Homes and Early Intervention Providers will be encouraged to build relationships to have direct communication with each other to make referrals and re-referrals when necessary
 - The parent, guardian and or legally authorized representative consent is necessary when sharing information beyond a referral
- ✓ The Early Intervention Official (EIO) will be able to have a direct communication with Health Homes to make a referral to a Health Home when the child is not eligible for Early Intervention or transitioning from Early Intervention, once verbal consent by the parent, guardian and or legally authorized representative is obtained
- ✓ The Health Home will have a direct communication to the County EIO to refer children that may be eligible for Early Intervention prior to Health Home enrollment



***DRAFT* PROCESS SCENARIOS** **for Stakeholder Feedback**



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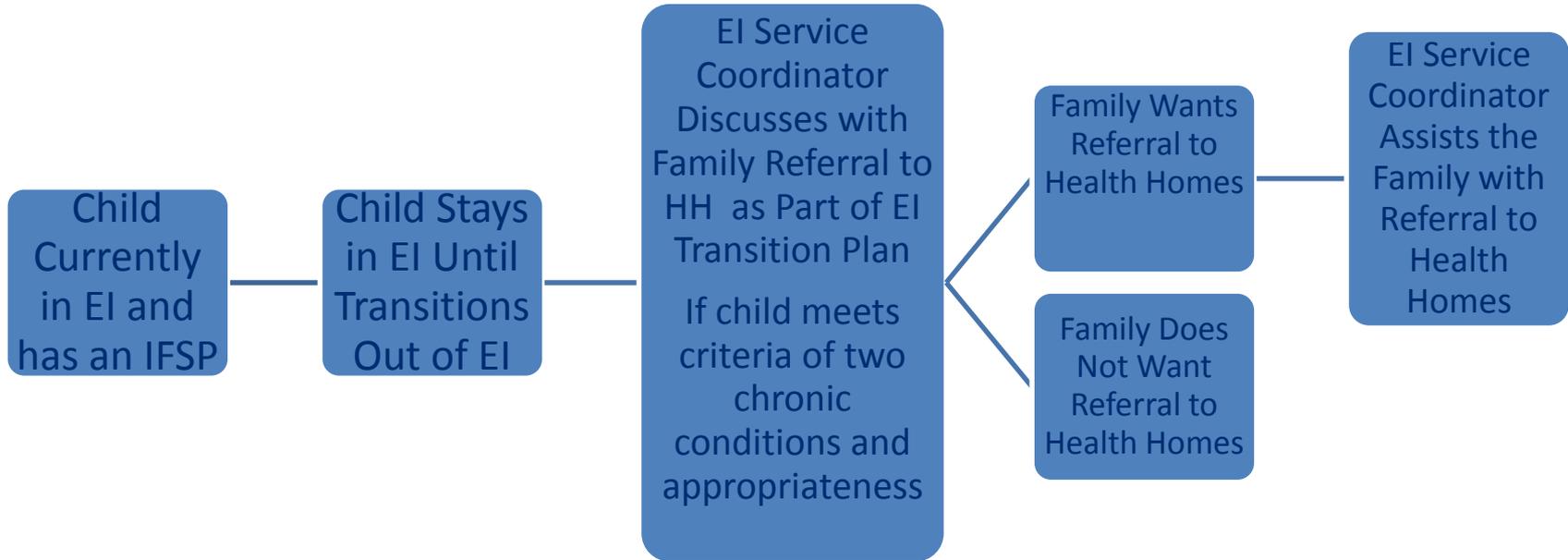
Early Intervention Children

December 2016 through March 2017

- Child in EI with an Individualized Family Service Plan (IFSP)
 - Stay in EI until transition out of EI
 - Child has an Ongoing Service Coordinator (OSC)
 - For EI children who will be transitioning out of EI during this time period, the OSC should assess if they believe the child might be eligible for Health Home Services
 - OSC will discuss with family possible referral to HH as part of the child's EI transition plan

December 2016 to March 31, 2017

REFERRAL TO HEALTH HOMES AS PART OF EARLY INTERVENTION TRANSITION PLAN



DRAFT Early Intervention referral to Health Home during ISC

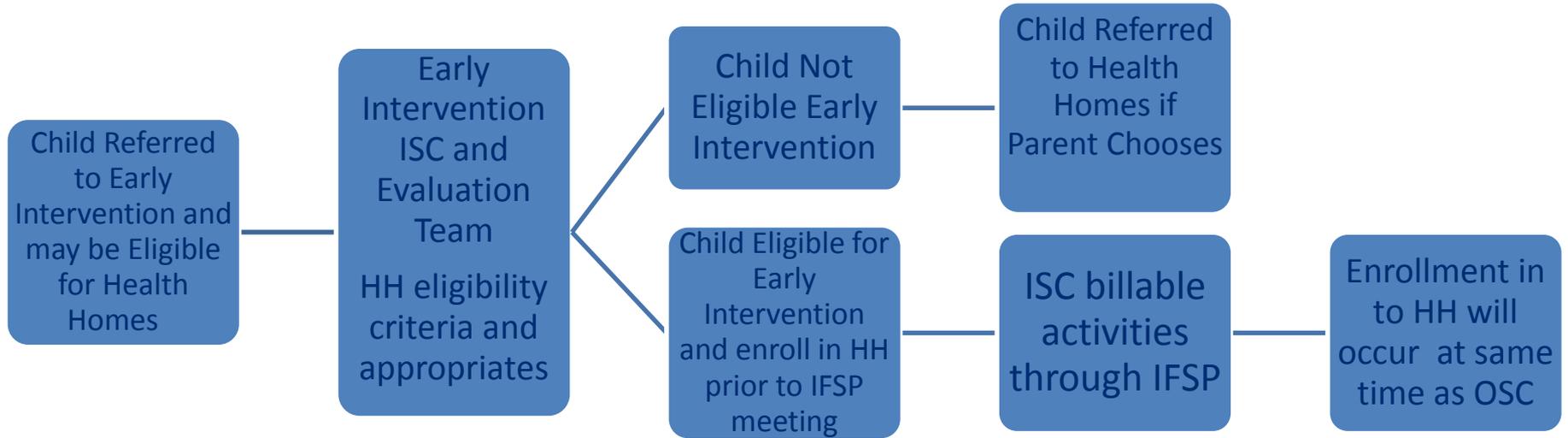
Scenario A (ISC): Initial Service Coordinator (ISC) refers child for Health Home services

- ✓ ISC and Evaluation team will assess whether they believe the child meets HH eligibility criteria and appropriateness
 - If the team believes the child is eligible for HH, the EI ISC will:
 - Discuss with the family and parent what is a HH, the roll of the HH and their interest to enroll
 - Refer the child through the HH Referral Portal and identify the family's chose of an EI OSC-Health Home Care Manager through the Medicaid Analytics Performance Portal (MAPP) (alignment with the child's managed care plan must occur)
 - If the EI ISC provider also provides EI OSC-HH CM, this agency will be able to maintain the referral as long as it is the family's choice
 - The referral will ideally occur during the initial IFSP development within a 45 day timeline
 - Parental consent for Health Home services must be obtained by EI OSC-Health Home Care Manager prior to child's enrollment into Health Home
 - ISC may bill for ISC services and IFSP activities prior to HH enrollment
 - The enrollment into HH will occur at the same time as EI ongoing service coordination would begin

REFERRAL TO EARLY INTERVENTION - MAY BE ELIGIBLE FOR HEALTH HOMES

March 2017

DRAFT Option



DRAFT Early Intervention referral to Health Home during OSC

Scenario B (OSC): EI Ongoing Service Coordinator (OSC) refers child for Health Home services

- ✓ During the implementation of Health Homes and or through periodic reviews and assessments of the child, the IFSP team may believe the child meets HH eligibility criteria and appropriateness
 - **Option #1**: If the EI OSC provider also provides HH Care Management services, the EI OSC will:
 - Discuss with the family and parent what is a HH, the roll of the HH and their interest to enroll
 - Refer the child through the HH Referral Portal and open the HH case with an enrollment segment through the Medicaid Analytics Performance Portal (MAPP) (alignment with the child's managed care plan must occur)
 - Child continues to have the same EI OSC to preserve continuity of care and limit multiple points of contact
 - Once child is enrolled in Health Home, the EI OSC will end billing for EI services coordination and begin billing for Health Home Care Management services based on acuity
 - This scenario includes those children who initially do not want to be referred to HH but later choose to join



DRAFT Early Intervention referral to Health Home during OSC

Scenario B (OSC): EI Ongoing Service Coordinator (OSC) refers child for Health Home services

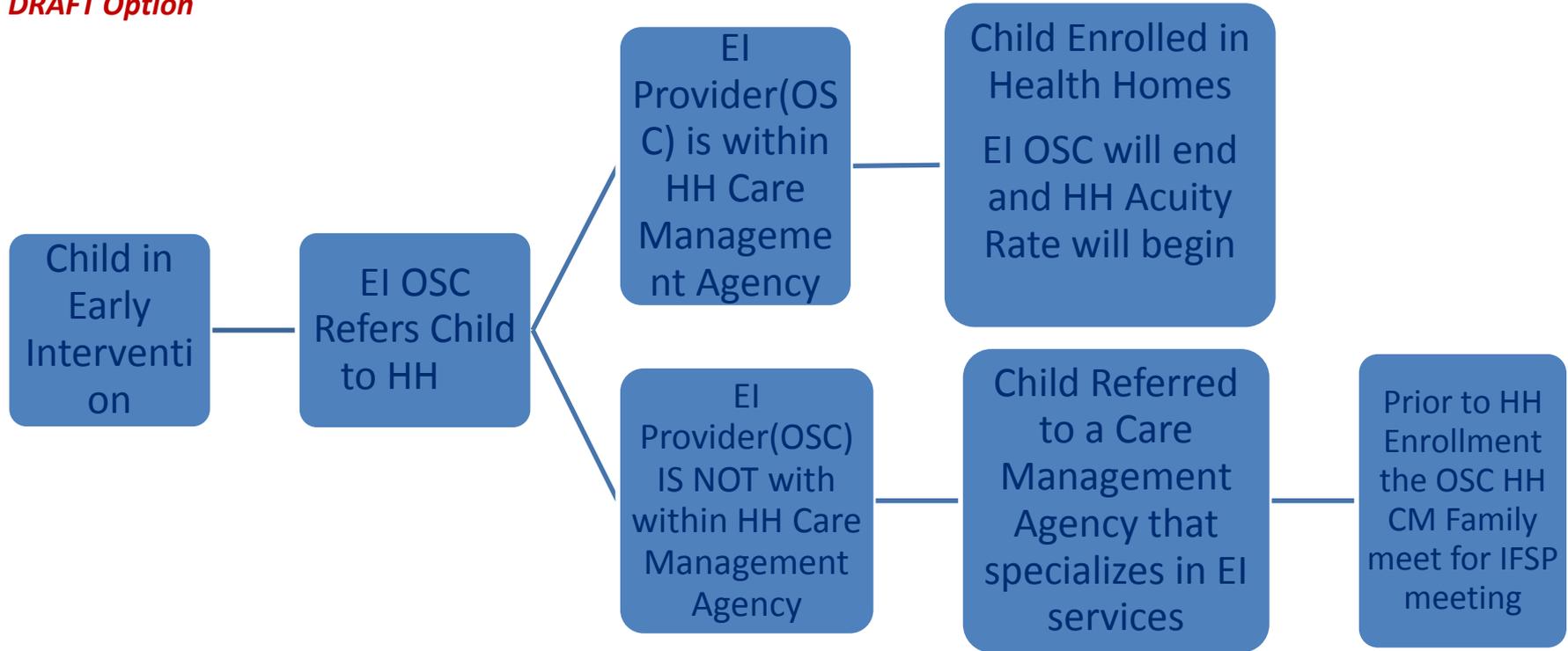
- ✓ During the implementation of Health Homes and or through periodic reviews and assessments of the child, the IFSP team may believe the child meets HH eligibility criteria and appropriateness
 - **Option #2:** If a EI OSC provider **does not** also provide HH Care Management services, EI OSC will:
 - Discuss with the family and parent what is a HH, the roll of the HH and their interest to enroll
 - Refer the child through the HH Referral Portal and identify the family's chose of an EI OSC-Health Home Care Manager through the Medicaid Analytics Performance Portal (MAPP) (alignment with the child's managed care plan must occur)
 - Prior to HH enrollment the OSC, HH CM, child's family, and IFSP team must meet to discuss child's IFSP
 - The EI OSC will bill for this meeting and date will be determined in which the enrollment into HH will begin so the EI OSC-HH CM can start to bill
 - **Low acuity until CANS NY is completed**
 - **CANS NY Acuity level as enrollment and complete CANS NY can be simultaneous**



CHILD In EARLY INTERVENTION - MAY BE ELIGIBLE FOR HEALTH HOMES

March 2017

DRAFT Option



DRAFT Transition Planning

Child transitions out of Early Intervention - it is determine the child no longer needs EI services, or, the child ages out of EI services

If not already in a HH CM

✓ The child is determine to meet HH eligibility criteria and appropriateness

- **Option #1:** If a EI OSC provider is also a HH Care Management Agency, follow option #1 of Scenario B of referral during OSC on previous slide
- **Option #2:** If a EI OSC provider **does not** provide Health Home services or cannot transition with the child, EI OSC will:
 - Discuss with the family and parent what is a HH, the roll of the HH and their interest to enroll
 - Information will be provided to EI OCS regarding which providers are EI OSC - HH CMA and interested in serving children transitioning out of EI
 - Relationship will be made between providers for a smooth transition (warm hand off)
 - Referral will be made through the MAPP Referral Portal
 - EI OSC (that is not also a HH CMA) must meet with HH CM to debrief on child's care management history (Part of transition Plan)

If already in a HH

- Continue child's HH care management without EI OSC service provision
- HH CM will conduct a new CANS NY to re-assess care management care plan
- Ideally the child and family will continue with current EI OSC-HH Care Manager that had been providing services

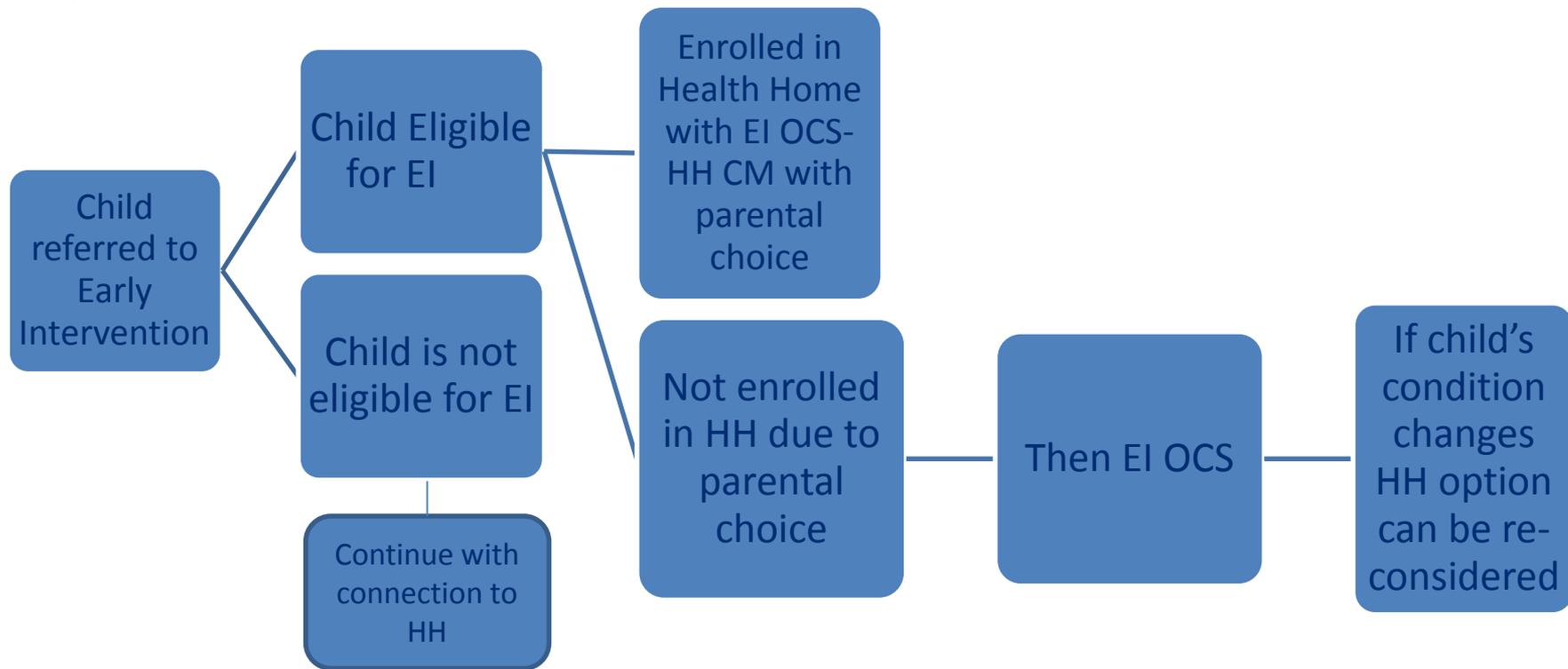


Enrolled HH Children Eligible for EI Discussion and Consideration for Feedback

- ✓ If children are already enrolled in a Health Home and possibly eligible for Early Intervention, leads to complications in:
 - Billing
 - Continuity of Care and a number of touch points with the family
 - Transitional concerns
- ✓ Considerations:
 - ✓ Prior to enrollment in HH, assess whether the child might be potentially eligible for EI services, make referral to EI
 - ✓ If children ages 0-3 years old are refer to a HH, HH CMA should assess if potentially eligible for EI services and make that referral during HH outreach
 - This would lead to:
 - Early Intervention expertise being utilized
 - Initial Service Coordination intact
 - Limit above complications
 - Focus on ongoing service coordination integration with HH



Enrolled HH Children Eligible for EI Discussion and Consideration for Feedback



Scenario: Benefits & Challenges of Integration

Benefits:

- Reduced system complexity through single point of contact for families
- Reduced duplication of services
- Increased continuity of care
- Increased accuracy in periodic assessments
- Expanded array of services
- Enhanced community relationship between Care Manager and service providers

Challenges:

- Training OSC to become HH CM
- Training for HH CM regarding EI
- Determining staff capacity needs
- Limited capacity during initial role out
- Becoming part of a Health Home network and oversight
- Network Adequacy
- Billing Processes
- Health Information Technology (HIT)
 - MAPP
 - CANS NY
 - NYEIS



Next Steps:

- ✓ Stakeholder Engagement
- ✓ Obtaining Stakeholder Feedback – **By Friday December 9, 2016**
 - NYSAHCO and NYSAC
 - EICC
 - EI providers doing service coordination
 - Health Homes
 - Health Home Care Management Agencies
- ✓ Surveying providers interest in providing HH CM and EI OSC services
- ✓ Planning steps for Implementation
 - Cross Training of requirements, responsibilities and standards
 - Approved EI provider process
 - Becoming part of a Health Home provider network
 - CANS NY Training
 - Systems training of NYEIS, HH CM systems, and DOH systems (i.e. MAPP)

Questions and Discussion



Updates, Resources, Training Schedule and Questions

- Please send any questions, comments or feedback on Health Homes Serving Children to: hhsc@health.ny.gov or contact the Health Home Program at the Department of Health at 518.473.5569
- Stay current by visiting our website: http://www.health.ny.gov/health_care/medicaid//program/medicaid_health_homes/health_homes_and_children.htm



Early Intervention and Health Homes

List of Acronyms

- IFSP: Individualized Family Service Plan
- ISC: Initial Service Coordinator
- LDSS: Local Department of Social Services
- LEICC: Local Early Intervention Coordination Council
- MAP: Medicaid Analytics Performance Portal
- MDE: Multidisciplinary Evaluation
- MOU: Memorandum of Understanding
- NYEIS: New York Early Intervention System (Data System)

Early Intervention and Health Homes

List of Acronyms

- NYSACHO: New York State Association of County Health Officials
- NYS-EIP: New York State Early Intervention Program
- OSC: Ongoing Service Coordination
- Section 4410: State Education Law section pertaining to 3 – 5 year olds (CPSE)

Health Homes Serving Children

List of Acronyms

- ACS: NYC Administration of Children Services
- AI: AIDS Institute
- ALP: Assisted Living Program
- ASA: Administrative Service Agreement
- BAA: Business Associate Agreement
- BHO: Behavioral Health Organization
- CAH: Care at Home
- CBO: Community Based Organizations
- CMA: Care Management Agency
- DEAA: Data Exchange Agreement Application
- EI: Early Intervention
- Emedny: Electronic Medicaid system of New York
- FFS: Fee For Service
- HCBS: Home and Community Based Services
- HCS: Health Commerce System
- HH: Health Home
- HHSC: Health Home Serving Children
- HHTS: Health Home Tracking System
- HIT: Health Information Technology
- LDSS: Local Department of Social Services
- LGU: Local Government Unit

Health Homes Serving Children

List of Acronyms

- MAPP: Medicaid Analytics Performance Portal (Health Home Tracking System HHTS)
- MCO/MCP: Managed Care Organization / Managed Care Plan
- MRT: Medicaid Redesign Team
- MMIS #: Medicaid Management Information Systems
- NPI #: National Provider Identifier
- OASAS: Office of Alcoholism and Substance Abuse Services
- OCFS: Office of Children and Family Services
- OMH: Office of Mental Health
- OMH-TCM: Office of Mental Health Targeted Case Management
- PMPM: Per Member Per Month
- SED: Serious Emotional Disturbance
- SMI: Serious Mental Illness
- SPA: State Plan Amendment
- SPOA: Single Point of Access
- SPOC: Single Point of Contact
- TCM: Targeted Case Management
- UAS-NY: Uniformed Assessment System
- VFCA: Voluntary Foster Care Agency